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IN THE

Supreme Court of the United States

October Term 1975

No. 74-895

VIRGINIA STATE BOARD OF PHARMACY, *et al.*,
Appellants,

against

VIRGINIA CITIZENS CONSUMER COUNCIL, *et al.*,
Appellees.

APPEAL FROM THE U. S. DISTRICT COURT FOR
THE EASTERN DISTRICT OF VIRGINIA

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS AND THE NATIONAL RETIRED TEACHERS ASSOCIATION

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MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND STATEMENT OF INTEREST OF *AMICI CURIAE*

The American Association of Retired Persons (AARP) and the National Retired Teachers Association (NRTA), of 1909 K Street, N.W., Washington, D. C. 20006, respectfully move the Court for permission to file the attached brief *amici curiae* for the following reasons, which reasons also disclose the interest of the *amici*.

AARP is a not-for-profit membership corporation of more than 7,500,000 persons over the age of 55. NRTA is a not-for-profit membership corporation of over 450,000 retired teachers and school administrators.

Among the purposes of AARP are: to improve the quality of life for older people in this country; to understand aging and its ramifications; to offer older citizens opportunities to plan a way of life designed to attain maximum enrichment; and to help foster equality of opportunity for the aging population in this country.

Among the purposes of NRTA are: to promote the professional and economic status of retired teachers; to afford retired teachers an opportunity for the interchange of information and opinion on subjects of common interest; to aid retired teachers to receive available services and benefits; and to facilitate united action amongst those devoted to the welfare of retired teachers.

The more than eight million members of these affiliated and jointly administered organizations represent the largest organized group of older Americans in the country. As retired persons, members of AARP and NRTA are generally on relatively fixed incomes and because of their age many also depend substantially on prescription drugs for their well being. Because of the high cost of drugs, this case is especially critical to the health and welfare of AARP and NRTA members and of all older Americans.

AARP and NRTA believe that the lifting of restraints against the publication and other accessible disclosure of the prices of prescription drugs will contribute to the general lowering of the retail cost of such drugs. Unrestricted factual price disclosure will facilitate more intelligent consumer selection of pharmacies by permitting consumers to consider the worth of the various services offered by particular establishments in relation to the prices charged.

Indeed, precisely because of *amici*'s concern over the high cost of drugs for older persons, *amici* inaugurated a not-for-profit pharmacy service for their members in 1959 in the nation's capital, which presently operates pharmacies at six locations throughout the United States.[1] These establishments (known as "Retired Persons Pharmacies" or the "NRTA/AARP Pharmacy Service"), which together represent the largest non-governmental mail order dispenser of prescription drugs, maintain both a "walk-in" and mail order business.

The NRTA/AARP Pharmacy Service was established with two basic objectives—to provide prescription and non-prescrip-

[1] Washington, D. C.; St. Petersburg, Florida; Long Beach, California; East Hartford, Connecticut; Kansas City, Missouri; and Indianapolis, Indiana.

tion medications to members at reasonable cost and with convenient delivery, and to influence others to provide prescriptions at lower prices, especially for older persons, through price competition. *Amici* are particularly interested in the outcome of this case, because of the effect statutes such as Virginia's have had in limiting the success of our second objective.

WHEREFORE, Movants pray that the attached brief *amici curiae* be permitted to be filed with the Court.

Respectively submitted,

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BRIEF *AMICI CURIAE*

Introduction

Amici have consistently taken the position before state legislative bodies, administrative agencies, and the Federal Trade Commission, that any state or municipal statutes or regulations, and any pharmacy association codes of ethics, which prohibit or otherwise limit the disclosure of information regarding prices of prescription drugs are inimical to the public interest. Based on our members' experiences, and our own affiliates' experience in operating six walk-in and mail order pharmacies (see attached motion, p. 2), the disclosure of drug prices in an easy to understand, readily accessible manner substantially assists consumers, particularly older consumers, in the following ways:

(1) by permitting intelligent comparison shopping and selection of a pharmacy based on an evaluation of price differences and services offered;

(2) by facilitating more meaningful communication between physician and patient, and pharmacist and patient, regarding relative price and quality of drugs; and

(3) by contributing inducements for pharmacists to lower the price of prescription drugs.

The statute presently before this Court totally eliminates the possibility for such accessible disclosure of price information. Under the statute a pharmacist is guilty of "unprofessional conduct" if he

> "publishes, advertises or promotes . . . in any manner whatsoever, any amount, price, fee, premium, discount, rebate or credit terms for professional services or . . . for any drugs which may be dispensed only by prescription." Virginia Code Ann. Section 54-524.35(3) (1974).

Thus, the challenged statute has effectively eliminated any general price disclosure except upon a specific (*personal*) request for the price of a specific drug. See Appendix, pp. 14-15 (stips. 23, 26).

The standards to be applied in measuring whether the Virginia statute passes muster under the First Amendment have been recently clarified by this Court's decision in *Bigelow* v. *Virginia*, —— U. S. ——, 43 L. W. 4734 (June 16, 1975). Thus, it is now unmistakably clear that the mere fact that words are written in a commercial context does not by that fact alone strip them of First Amendment protections. In *Bigelow* the Court ruled that the lower courts had "erred in their assumptions that advertising, as such, was entitled to no First Amendment protection. . . ." *Bigelow* v. *Virginia, supra,* at 4739.

Bigelow did not, of course, proscribe *all* regulation of advertising. "Advertising, like all public expression, may be subject to reasonable regulation that serves a legitimate public interest." *Ibid.* In *Bigelow* the Court had no occasion to delineate the "precise extent" to which a state may regulate advertising that relates to activities legitimately subject to state regulation or prohibition, such as the sale of prescription drugs, *ibid,* but it did clearly caution that even where some regulation of commercial activity is permitted, the "relationship of speech to that activity may be one factor, among others, to be considered in weighing the First Amendment interest against the governmental interest alleged." *Ibid.*

Amici submit that the task before this Court is to weigh the public's interest in obtaining easily accessible information regarding drug prices and the role of statutes such as Virginia's in blocking such accessibility, against any legitimate interests of the state in protecting the public's health and welfare which may be served by a ban on drug price advertising.[1] In approaching this task, *amici* urge the Court to consider both the fact that advertisement of drug prices barred by the statute in question may contain "factual material of clear 'public interest'," *Bigelow* v. *Virginia, supra,* at 4738, and the fact that the Virginia statute, by failing to narrowly aim at legitimate state concerns, prohibits speech far beyond that which might be reasonably necessary to protect the public health, safety and welfare. See, e.g., *Shelton* v. *Tucker,* 364 U. S. 479, 488 (1960); *Broadrick* v. *Oklahoma,* 413 U. S. 601, 611 (1973); *Terry* v. *California State Board,* —— F. Supp. ——, (No. C-74-1091, N. D. Cal., May 12, 1975).

Amici will demonstrate below that older Americans have a critical need for information regarding the prices of prescription drugs, and therefore an interest in receiving such information deserving of First Amendment protection, see, e.g., *Lamont* v. *Postmaster General,* 381 U. S. 301, 307 (1965), and that the Virginia statute sweeps too broadly by flatly prohibiting *all* advertising of prescription drug prices.

ARGUMENT

Consumers, especially older persons, have a critical need for accessible price information on prescription drugs, and the flat prohibition against disclosure of such information deprives them of their First Amendment "right to know."

A. The High Cost of Prescription Drugs Threatens the Health of Older Americans.

The drug industry is big business in this country, and older Americans are its best customers. In 1974, $9.7 billion was

[1] "[A] court may not escape the task of assessing the First Amendment interest at stake and weighing it against the public interest allegedly served by the regulation." *Bigelow* v. *Virginia, supra,* at 4739.

spent on drugs, approximately 10% of *all* health related expenditures.[2] Over the past few years these expenditures have increased about $700,000,000 each year,[3] and so we may confidently assume that the amount spent on drugs will continue to remain at such astronomical levels and will likely continue to grow.

Persons over age 65 contribute by far the largest proportion of expenditures to this high national total. Although such persons represent only 10% of the nation's population, in 1973 they accounted for almost *one-quarter* of all drug expenditures.[4] This represented *per capita* drug expenditures on behalf of persons over 65 of $97.27 in 1973, compared to less than half the amount, $41.18, for all age groups.[5] Preliminary estimates for 1974 indicate that *per capita* drug costs for persons over age 65 have increased to $103.17, compared to $45.14 for all age groups.[6]

The reason for such a high rate of drug and other health related expenditures for older persons is obvious. As Social Security Administration researchers have observed, "[s]ince the average aged person is twice as likely to have one or more

[2] Nancy L. Worthington, "National Health Expenditures, 1929-74," Social Security Bulletin, HEW, SSA, Vol. 38, No. 2, p. 9, Table 2 (Feb. 1975). This amount includes all drugs, not just prescription drugs, and also includes "drug sundries."

[3] *Ibid.*

[4] Barbara S. Cooper and Paula A. Piro, "Age Differences in Medical Care Spending, Fiscal Year 1973," Social Security Bulletin, HEW, SSA, Vol. 37, No. 5, pp. 3, 4 (May 1974). In FY 1973, of $8.8 billion for all age groups, the over-65 group spent $2.1 billion. This proportion is consistent with the elderly's overall 28% of the nation's health care expenditures. *Ibid.* Preliminary estimates for 1974 indicate these percentages have held constant. See Marjorie Smith Mueller and Robert M. Gibson, "Age Differences in Health Care Spending, Fiscal Year 1974," Social Security Bulletin, HEW, SSA, Vol. 38, No. 6, p. 4, Table 1 (June 1975).

[5] Cooper and Piro, *supra,* at 6, Table 2.

[6] Mueller and Gibson, *supra,* at 5, Table 2.

chronic conditions and more likely to be limited in activity, he experiences more and costlier illnesses than the average person under age 65."[7] Indeed, statistics compiled by the U. S. Office of Management and Budget reveal an even greater likelihood of ill health and limited activity than Social Security Administration estimates. Thus, in 1971, 38.7% of all Americans over age 65 were limited in at least one major activity due to chronic conditions, compared to only 9.3% for all age groups, and 16.9% of the over 65 group were unable to carry on *any* major activities because of chronic conditions, compared to only 2.9% for all age groups.[8]

Given the especially great demand for drugs by persons over age 65, it is significant that almost all such expenditures are out-of-pocket for this important item of health care, and that of all categories of health care, out-of-pocket costs are rising fastest for drugs. Thus, in 1973, of the $97.27 *per capita* expended for drugs by this age group, $85.26 or almost 90% was borne from private funds, and only $12.01 from public sources.[9] Moreover, while out-of-pocket hospital costs rose only $3 per year during 1966-1973, and professional services only $1, drugs and sundries rose $27 or almost 50% in that period.[10]

These expenditures for drugs are especially burdensome to the over age 65 population in this country in light of the fact that their income is, on the average, only half of the income

[7] Cooper and Piro, *supra,* at 3.

[8] Social Indicators, 1973, Statistical Policy Division, Office of Management and Budget, p. 36, Table 1/18 (prepared for publication by the Social and Economic Statistics Administration, Dept. of Commerce).

[9] Cooper and Piro, *supra,* at 6. This is a sharp departure from the usual source of expenditures for health care generally for the aged. Of slightly more than $1,000 *per capita* spent on health care in 1973, about two-thirds was financed from public funds. *Ibid.* Of the $85 spent for "drugs and drug sundries," approximately $59 was for prescription drugs. FTC, Report from Staff Investigating Retail Prescription Drug Price Disclosures, p. 29, Jan. 28, 1975 (hereinafter, FTC Report).

[10] FTC Report, *supra,* p. 29.

of all age groups (when they live with relatives)[11] and only about one-fifth that of all age groups when they live alone.[12] It should be noted that Medicare does not cover the cost of outpatient prescription drugs, 42 U.S.C. §§ 1395k(a)(1), 1395x(s)(2)(A), and that Medicaid, which does cover prescription drugs in Virginia, is available with full coverage only for persons over age 65 who have annual incomes less than $1,900 if living alone, or $2,500 if living with a spouse, Virginia Medical Assistance Program Policy Manual, § 301.1(D)(4)(c) (January, 1975).

The above statistics are compelling in their demonstration of the burden falling on older persons with respect to their need for drugs. However, based on our experience, and on surveys conducted of our members, we do not believe any such statistics on *average* drug expenditures accurately reflect the disproportionate burden falling on significant members of chronically ill and/or low income older Americans. Thus, for example, in a survey taken of our members in 1974, it was found that virtually all of the 2,000 respondents spent at least 10% of their income on medication, with some spending as much as 40-45%. Because of differing incomes, the range in dollars ran from less than $200 per year to well over $1,000.[13]

B. Older Americans Need Readily Accessible Information Regarding Prescription Drug Prices.

Presently effective drug pricing policies under statutory schemes such as Virginia's make it exceedingly difficult, if not

[11] Social Indicators, 1973, *supra,* p. 176, Table 5/3. The median family income in 1971 was $10,285 for all families, and only $5,453 for all persons over age 65. *Ibid.*

[12] In 1970, when the median income of all over age 65 families was $5,053, the median income for persons over age 65 living alone was only $1,951. Dep't of Commerce, Social and Economic Statistics Administration, Bureau of the Census, Current Population Reports, Series P-23, No. 43 (Feb. 1973), "Some Demographic Aspects of Aging in the United States," p. 29, Table 23.

[13] 1974 High Drug Cost Survey of NRTA and AARP Members, compiled for Sen. Edward M. Kennedy, Chairman, Senate Subcommittee on Health, Sept. 24, 1974, pp. 1-2.

impossible, for older consumers to make rational decisions in the purchase of prescription drugs. What such persons need is the ability to educate themselves as to the pricing policies of pharmacies in their area or pharmacies accessible to them by mail. The court below correctly construed the First Amendment as proscribing laws which prohibit the advertisement of price information because of the education purpose thereby served.[14]

In order to demonstrate this need for education or information, we point first to the record in this case which, together with countless surveys conducted by private groups, government agencies and litigants in similar cases, establishes that prescription drug prices differ dramatically from neighborhood to neighborhood, and from store to store. Thus, for example, the record below demonstrates price ranges (i.e., the percentage difference between low and high price surveyed) for Achromycin of 80% in northern Virginia, 140% in Richmond, and 241% in the Newport News-Hampton area. Appendix, p. 14, stip. 22. An American Medical Association survey revealed price differentials in Chicago of up to 1200%. *Ibid.*

The record confirms *amici's* own surveys of prescription drug prices. For example, in 1974 AARP volunteers assisted a public interest research group in a survey of the cost of three prescription drugs (Actifed, Ornade and Aldactazide) at 28 pharmacies in the nation's capital. The results were astounding:[15]

> —Aldactazide, a drug commonly prescribed for older persons with hypertension, had the widest price gap of $3.38. The lowest price offered was $4.57, the highest $7.95, for 36 tablets.
>
> —Actifed, a decongestant and antihistamine, varied as much as $2.07. The lowest price for 24 pills was $1.43, the highest $3.50, a price range of 245%.
>
> —Ornade, another antihistamine, ranged from $2.56 to $4.95 for 20 capsules.

[14] See, e.g., *Virginia Citizens Consumer Counsel, Inc.* v. *State Board of Pharmacy,* 373 F. Supp. 683, 685, 686 (E. D. Va. 1974) and *Terry* v. *California State Board, supra.*

[15] The survey results were reported in the AARP News Bulletin, December 1974, pp. 1-2.

> —Ten stores were inconsistent in their pricing within a 24 hour period.
>
> —Fourteen stores had in-store price discrepancies of as much as $1.00 for the same prescription.

The above and similar evidence of price variations was reviewed by the Federal Trade Commission staff. As noted by the staff in its recent report to the Commission,

> "The evidence . . . clearly establishes that throughout the United States there exist significant differences in the retail prices charged for the same prescription drugs sold by different pharmacies in the same communities. Existing surveys and studies in 20 states and the District of Columbia show that a patient with a prescription to fill may be charged widely different amounts by different pharmacies within the same community. Indeed, several surveys allege that there are great price differences for the same drug between pharmacies on the same block or within short walking distances."[16]

Because drug prices do vary so greatly, the ready availability of this price information is especially important to older persons who have, as demonstrated, heavy drug expenses and limited incomes.[17] The evidence of wide variation in the selling price of prescription drugs, however, does not, as one might have thought, reveal a free market in which consumers, including older consumers, are afforded a choice as to where to fulfill their drug needs. On the contrary, because of a pattern of concealment of purchase prices, fostered by legislation such as that involved in this case, consumers are generally unable to make a knowing and intelligent selection of retailer, and thus end up with the best price for their needs only by chance, if at all.

Pre-purchase price disclosure could be accomplished in a variety of ways. Verbal disclosure on request in the pharmacy, telephone disclosure, posters, price lists in pamphlet form for

[16] FTC Report, *supra,* p. 119. See also *Id* at pp. 120-127.

[17] As an HEW task force has recognized, the need to obtain price information is "particularly important in the case of long-term maintenance drugs," i.e., those needed by older Americans. Second Interim Report and Recommendations of the Task Force on Prescription Drugs, HEW, August 30, 1968, pp. 20-21.

out of store use, and media advertisements, are prime examples.[18] However, as the FTC has indicated, it has

> "reason to believe that . . . the availability of price information for prescription drugs is inadequate to enable consumers to use price in a rational manner as a consideration in making purchase decisions." 40 Fed. Reg. 24032 (June 4, 1975).

Legislative restrictions, such as those used by Virginia, have been identified by the FTC as a primary reason for unavailability of price information. *Ibid.* FTC staff, in commenting on the fact that consumer access to prescription drug prices is "totally inadequate," observed that

> "the *major obstacle* to such access appears to be the existence of a panoply of state laws and pharmacy board regulations which prohibit or severely restrict the disclosure and advertising of prescription drug prices." FTC Report, *supra,* p. 33 (emphasis added).

Moreover, prohibitory legislation such as Virginia's has its most significant impact on older persons, because such legislation *prevents the use of those very disclosure techniques which are most essential for their needs.* Thus, the statutory classification of any publication or advertisement of a price, amount, or discount as unprofessional conduct, would seem to clearly bar the printing and distribution of price lists, and the advertising of prices in the media. *Amici* believe that unless such methods of disclosure are authorized, older consumers will be unable to obtain necessary price information since such methods are the *only* forms of price disclosure which are tailored to meet the needs and capacities of most older persons.

The older person requires modes of price disclosure which enable him or her to conveniently compare drug costs from retailer to retailer. Because of limited mobility due to physical infirmities, older consumers frequently do not have the ability to shop around, obtain information for specific drugs and make the necessary comparisons. As noted above, almost 40% of persons over age 65 are limited in activity because of chronic physical conditions. As the FTC staff has concluded,

[18] FTC Report, *supra,* p. 17.

> "[t]he elderly person, even more so than consumers in general, needs modes of disclosure which enable him or her to make price comparisons easily and conveniently. For the elderly person who has curtailed his or her activity the most convenient modes of disclosure are those which are currently least available; that is, those that can be exercised from the home. Telephonic disclosure of prices, price lists retained by the consumer, and newspaper price advertisements would appear to be those most easily and effectively utilized by senior citizens." FTC Report, *supra,* p. 31.[19]

Of these effective methods of disclosure for older persons, all but telephonic disclosure is prohibited by the Virginia statute.

The only other method of price disclosure not interfered with by the statute is face-to-face in-store disclosure, i.e., disclosure to a customer or comparison shopper who visits the store and either makes a purchase or specifically inquires as to the price.[20] Quite apart from the physical burdens noted above

[19] While telephonic disclosure is theoretically permitted, the record in this case indicates that "some pharmacies . . . refuse to quote prescription drug prices over the telephone for several reasons" including "the mistaken belief" that such disclosure is prohibited, and the *deliberate* policy decision not to disclose because of the belief that "consumers may misread prescriptions." Appendix, p. 15, stipulation 25. This experience is confirmed by *amici's* survey in the District of Columbia, discussed *supra,* in which 39% of the pharmacies telephoned refused to disclose prices over the telephone. AARP News Bulletin, December 1974, p. 2.

[20] One form of in-store disclosure that *does* have considerable merit, the posting of a placard with prices of representative drugs listed, is also barred by the Virginia statute. When such posters are uniform from store to store, list selling price for a specific quantity, are conspicuously posted and readily accessible without the aid of a pharmacist or a clerk, they are an aid to consumers. However, standing alone, even if such posting *were* permitted by the statute, it would not relieve older persons of the physical and financial burden of comparison shopping. As the FTC report indicates:

> "posters are of only limited usefulness to consumers interested in comparison shopping for prescription drugs. If price posting is the only means of disclosure permitted, consumers must go from store to store comparing prescription prices thus increasing search time costs. Such comparisons may well be impossible for the elderly, infirm, or immobile." *Id* at pp. 251-52.

which are attributable to limitations of price disclosure to on-site visits, the financial cost of such shopping is often prohibitive to older persons who lack the financial means to finance the transportation costs. Moreover, such costs add an "implicit" price to the sales price which, as a practical matter, renders the entire comparison shopping effort counter-productive and thus useless.[21]

In sum, the FTC staff found that in-store price disclosure which is the "most prevalent mode of price disclosure,"

> "is apt to be the *least satisfactory for the elderly person* who suffers from decreased mobility and is unlikely to have either the means of transportation or the stamina to go to several pharmacies to compare prices and services." FTC Report, *supra,* pp. 30-31 (emphasis added).

This conclusion parallels an earlier one of the Maryland Court of Appeals, which noted, in the course of its opinion invalidating on due process grounds a statute similar to Virginia's, that the record in that case revealed that

> "[t]he ban on advertising prescription drug prices imposes a burden on senior citizens because they are unable to conduct any investigation, such as by reading advertisements, to learn the available prices for drugs. Many of these same persons have a great need for maintenance-type drugs." *Maryland Board of Pharmacy* v. *Sav-A-Lot, Inc.*, 270 Md. 103, 311 A. 2d 242, 252 (1973).

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[21] Professor George Stigler describes this principle as follows: "If the costs of search becomes very expensive, the consumer must forego search and become satisfied with higher purchase prices." G. Stigler, *The Organization of Industry* (1968), p. 175. See also FTC Report, *supra,* p. 314, where the staff noted that since the "time and effort" costs to the consumer to obtain the relevant drug price information "exceeds the likely benefit, there is often no practical way for consumers to compare prices."

Amici believe that the only forms of price disclosure which really meet the special needs of older persons are price lists which are made available for distribution, and media advertising. Thus, price lists provide a ready reference to prices for patients who are taking a number of prescribed drugs or who may wish to know the price of a newly prescribed drug or who require maintenance drugs on a continuous basis. Price lists can be taken from a store (or mailed by mail-order pharmacies), and collected by consumers for future use in making side-by-side comparisons to other stores' prices. Price lists can also be collected and analyzed by unions, consumer organizations, and other similar groups for distribution to members and others for price comparison purposes. Media advertising serves a similar function.

Price lists and media advertising thus provide a cheap, physically undemanding method of price evaluation for older persons. Indeed, the prohibition on distribution of price information in many states has prevented the inclusion of prescription drugs on the Retired Persons Pharmacies price list distributed to members of AARP and NRTA. This, in turn, obviously has weakened the effectiveness of our affiliated mail-order pharmacies in bringing reduced drug prices to our members.

Amici wish to emphasize that they are not suggesting that price is the *only* relevant factor in a purchase decision. Certainly services provided by a particular pharmacist, such as credit, convenient location, delivery, consultation, use of patient profiles, etc., are all influential to some degree in the decision as to where to purchase one's drugs. If provided with sufficient information the consumer could judge how much these professional or merchant services are worth to him or her, or whether greater inconvenience or fewer services should be tolerated in favor of reduced prices.

Yet, in the absence of adequate price information an informed choice simply cannot be made. Statutes such as Virginia's make this judgment *for* the consumer, and this is especially detrimental to price conscious older persons, many of whom would undoubtedly value price over ancillary services. It must be

remembered that the filling of the prescription according to the directions of the physician satisfies the specific health need of the customer. While ancillary professional services may be beneficial to consumers who want them, a choice in favor of a low price will not be a sacrifice of health requirements.

Accessible methods of price disclosure would serve two additional, but related, objectives to the objective of reasoned comparison shopping. First, the greater awareness of price information would be an assist to patients' reasoned discussions with physicians concerning the possibility of prescribing lower priced *equivalent* drugs by informing both patient and doctor of the fact of price differences. A result of greater price consciousness would likely be a modification of physician prescribing habits, and an overall lowering of drug prices benefiting all consumers.

Second, *amici* believe that if price information were made accessible to the public, prices would tend to decrease *generally*, quite apart from consumers' ability to find the best *relative* price. The interference with free market conditions, which is, after all, what price disclosure restraints are all about, necessarily reduces pressures for decreased prices because consumers are not exercising their "dollar ballots" on the basis of price. Thus, the FTC has declared that it has reason to believe that "the inadequate availability of retail price information for prescription drugs prevents or hinders price competition among retail pharmacies." 40 Fed. Reg. 24032 (June 4, 1975).

Concrete evidence that availability of price information would tend to bring down price levels is the following advertisement from a local newspaper in Vermont. Obviously reacting to substantial competition provided by *amici*'s affiliated mail order pharmacies (probably a result of "word of mouth" publicity for their low prices), a Burlington, Vermont pharmacy placed the following ad:[22]

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[22] Burlington Vermont Free Press, Dec. 9, 1974.

"HERE WE GO
AGAIN

AARP* Prescription Prices are 20% to 40%
Below Conventional Pharmacy Prices
NOW for our own Vermont Senior Citizens
we will MEET THOSE LOW, LOW PRICES
No need to send out of State
No 7 to 10 day delay
Just present Proof of Purchase Sales Slip
from AARP, Name and Quantity of
Medication.
ISN'T THIS BETTER THAN THE 10%
DISCOUNT . . . ??

*American Association of Retired Persons"

Surely the general availability of price information would induce other pharmacists to reevaluate their price policies, and establish price levels which take into consideration the desires of their potential customers.

C. Less Drastic Means of Regulation Would Protect the Public Health and Welfare.

This Court has long recognized that statutes restricting or burdening First Amendment rights must be narrowly drawn, and that where less drastic means are available to serve the asserted purpose, such methods must be used. See, e.g., *Shelton* v. *Tucker, supra; Broadrick* v. *Oklahoma, supra; Terry* v. *California State Board, supra;* see also *Hiett* v. *United States*, 415 F. 2d 664, 673 (5th Cir. 1969), *cert. denied*, 397 U. S. 936 (1970). A state legislature may not use a "blunderbuss" approach when it legitimately seeks to regulate within a small sphere of unprotected activity. *Ibid.*

States like Virginia that prohibit price disclosure by advertising have generally defended such statutes on the basis of a supposed interest in protecting public health and welfare of their citizens. While any such interests may well be relevant in determining "the precise extent to which the First Amendment

permits *regulation*" of drug price advertising, since, as noted above, the sale of drugs is an activity "the State may legitimately regulate," *Bigelow* v. *Virginia, supra,* at 4739 (emphasis added), *amici* submit that any conceivable interest of the state could be furthered by a more narrowly drawn statute that does not disregard consumer interests in the zeal to protect such interests.

Thus, the statute now before this Court *prohibits the purely factual disclosure of price.*[23] So, for example, a factual advertisement or price list that discloses *only* such facts as strength, quantity, or price of a prescription drug would nonetheless be prohibited, *even if unaccompanied by promotional advertising. Amici* would probably have little quarrel with reasonable regulation of drug advertising that, for example, required uniform information such as brand name, generic name (if product available as generic), quantity and price. Nor would they quarrel with a regulation which required the maintenance of advertised prices for a reasonable period of time, so as to preclude "bait' or "loss leader" advertising. Similarly, advertising that unfairly promotes the use of a drug, extravagantly extols its virtues and safety, discloses recommended usage or encourages unnecessary consumer purchases, might be subject to legitimate and reasonable state regulation.

The statute in question is not so finely tailored, however, since it bars *all* advertising in the desire to control some.[24] The purely *factual* and *informational* advertising barred by the Virginia statute, objectively measurable and thus verifiable, stands in sharp contrast to the subjective professional advertising before this Court in cases such as *Semler* v. *Oregon State Board of Dental Examiners,* 294 U. S. 608 (1935). In *Semler,* the proscribed conduct was advertising of "professional superiority," use of large and "glossy" displays and guarantees of professional performance. *Id* at 609. While the dentist in *Semler* contended the statute was invalid since it proscribed *truthful* advertising, i.e., he contended that he was *in fact* superior, *ibid,* this Court noted that in order to protect the public from unscrupulous claims by those who would "prey" upon a "susceptible" public, *id* at 612, the legislature was not "bound to provide for determinations of the relative proficiency of particular practitioners." *Ibid.* Accordingly, the state statute in *Semler* was sustained against a due process challenge.

As noted, the speech proscribed here is *factual,* easily verified, and thus not subjective. Accordingly, the broad sweep of prohibition is not justified. As the Maryland Court of Appeals noted,

> "[w]hen describing the quality of services, advertising may be prone to distort; when listing definite prices or discounts, it serves as *a tool to educate rather than deceive.* Thus, pharmacists may be distinguished from other 'professions' . . . in that price advertising of retail drugs casts no unfavorable reflection on the professional aspect of pharmacy by deceiving the public about the type of services available." *Maryland Board of Pharmacy* v. *Sav-A-Lot, Inc., supra,* 311 A. 2d at 248 (emphasis added).

In sum, if and to the extent *promotional* advertising is believed to be injurious to the public interest, then *such advertisement alone* should be subjected to the state regulation. Virginia, instead, has used a blunderbuss technique that prohibits all advertising in order to eliminate the objectionable.

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[23] This is the Court's first opportunity to decide whether purely *factual* advertising by a regulated profession may be prohibited in the face of a First Amendment challenge. See *Head* v. *New Mexico Board,* 374 U. S. 424, 432, n. 12 (1963); *Pittsburgh Press Co.* v. *Human Relations Commission,* 413 U. S. 376, 387, n. 10 (1973); *Bigelow* v. *Virginia, supra,* at 4739.

[24] Cf. *Weinberger* v. *Salfi,* —— U. S. ——, 43 L. W. 4985 (June 26, 1975); *Mourning* v. *Family Publications Service, Inc.,* 411 U. S. 356 (1973). In *Salfi, only because the Court found no constitutionally protected status, id* at 4992, did it permit the Congress to regulate with a broad sweep, including in its scope cases not presenting the evil the legislation sought to avoid, *id* at 4993. See also *Dandridge* v. *Williams,* 397 U. S. 471, 484 (1970).

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted,

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